University Hospitals Urgent Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name					
Previous Name, if applicable					
Last 4 digits of SSN		**Date of Birth**			
Address					
City		**State**		**Zip code**	
Primary Phone		**Email Address**			

University Hospitals Urgent Care Healthcare Facility/Facilities:

I authorize representatives from the following facility/facilities to disclose health information as directed below:

University Hospitals Urgent Care information to be released:

☐	Complete Medical Record	Visit Date	

OR Partial Medical Record to be released:

☐	Electronic Continuity of Care/Electronic Abstract	Visit Date	
☐	Billing Records	Visit Date	
☐	History and Physical	Visit Date	
☐	Office Notes/Progress Notes	Visit Date	
☐	Discharge Summary	Visit Date	
☐	Lab Results	Visit Date	
☐	X-rays	Visit Date	
☐	EKG Reports	Visit Date	
☐	Itemized Bill	Visit Date	
☐	Other (please specify)	Visit Date	

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University Hospitals Urgent Care information to be released to:

Name of Organization/Person					
Address					
City		**State**		**Zip code**	
Phone		**Fax**			

Purpose of Disclosure

☐ At my Request

☐ Other: _____

Expiration of Authorization

Unless I request in writing otherwise, I understand that this authorization will expire on: _____ (Insert expiration date or event). If I do not specify an expiration date or event this authorization will expire ninety (90) days from the date on which I signed this authorization.

Right to Revoke Authorization

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the University Hospitals Urgent Care facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the University Hospital Urgent Care Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Re-disclosure

I understand that if my health information is disclosed to a party other than a health care provider, health plan or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Fees

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

Refusal to Authorize Use and/or Disclosure

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that University Hospitals Urgent Care may decline to treat me if I refuse to sign this authorization only if: (l) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

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Release and Waiver

If the health information that I have requested University Hospitals Urgent Care to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release University Hospitals Urgent Care, each of the University Hospitals Urgent Care facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

Patient Signature (or Patients Representative) _____

Printed Name _____ Date _____

Description of Authority to Act for Patient _____

Note: *a copy of this completed, signed, and dated form must be provided to the patient and/or Patient's representative and a copy must be placed in the patient's medical record*